Maternity Program Questions and Answers 10/26/2009

1. Whose responsibility is it for the professional component of ultrasounds both inpatient and outpatient? **Response:** The professional component is the responsibility of the Primary Contractor.
2. If a maternity patient presents to L&D and is admitted with false labor will this be considered as an inpatient admission? **Response:** Yes, if the admission level of criteria is met, it will count against the inpatient day limit of 16.
3. Why are claims for maternity ultrasounds performed after October 1 rejecting? **Response:** System changes that were required were not put into the system until October 15, 2009. Any claims submitted prior to this date will need to be resubmitted.
4. Can inpatient claims for deliveries be submitted electronically? **Response:** Yes.
5. Why are lab services denying with 1826 (bill svc for maternity care recipients as global fee)? **Response:** Research of this claim indicated that the hospital was billing procedure codes that were on the global associated fee schedule as well as codes that were not. The provider must remove the codes which are on the global associated fee schedule and resubmit the claim.
6. How are hospitals reimbursed for patients admitted for observation less than 24 hours? **Response:** There is currently no mechanism to allow maternity outpatient observation claims to pay as fee-for-service through the claims processing system. This was previously associated with global methodology between the PC and the hospital. If the recipient meets the inpatient level of care then an inpatient day may be billed.
7. How many ultrasounds can a maternity patient receive before requiring prior authorization? **Response:** Seven until January 1, then the responsibility of payment for maternity ultrasounds reverts back to the Primary Contractor.
8. Whose responsibility is it to request the prior authorization for maternity ultrasounds? **Response:** The physician who is ordering the ultrasound.
9. Is there a mechanism for obtaining additional hospital inpatient days for maternity patients that at delivery have previously exhausted their inpatient day's benefit? **Response:** Yes**,** an additional two days for a vaginal delivery and four days for a c-section delivery may be covered for maternity recipients who have exhausted their inpatient benefit. The additional days must be requested through normal prior authorization channels and within 30 days of the discharge date. The form 342 is the required form to be submitted. It should be mailed or faxed to HP and can be found on the Medicaid website. The additional days must meet the Medicaid inpatient care criteria.

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Additionally, the same form/process is required for obstetrical ultrasounds. Recipients participating in the Maternity Care program can receive up to seven obstetrical ultrasounds for each pregnancy before authorization must be obtained. All ultrasounds must be for reasons of medical necessity. Each ultrasound must be supported with a medical diagnosis and the benefit of the procedure being done.
10. Patient delivered in the Emergency Department parking lot and was admitted for post-partum care, can an inpatient day be billed? **Response:** The inpatient day can be billed if the recipient meets the level of care criteria.

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